MEDICARE PATIENTS ONLY

DERMATOLOGY ASSOCIATES
OF DENISON

2014 Quality Reporting for Medicare/Railroad Medicare Patients

Patient Name:	Date of Birth:	Date of Service:

(Measure 47)
Do you have an Advanced Care Plan (Living Will)? ☐ YES ☐ NO *(1123F/8P)*

IF YES: Please name your Surrogate Decision Maker? _____ *(1123F)*

☐ Please check this box if you are unable to, or choose not to name your Surrogate Decision Maker. *(1124F)*

(Measure 110)
Have you received an Influenza Immunization this year (*October 2013-March 2014*)?
☐ YES *(G8482)* ☐ NO *(G8484)*

(Measure 111)
Have you EVER (in your entire life) received a Pneumococcal Vaccination?
☐ YES *(4040F)* ☐ NO *(4040F/8P)*

(Measure 128)
Please list your HEIGHT:_____ AND WEIGHT:_____
For Internal Use Only:
BMI Score:_____ ___Normal (G8420) ___Abnormal (G8419) ___Not Calculated (G8421)

(Measure 130)
Have you provided our office with a list of current medications? ☐ YES *(G8427)* ☐ NO *(G8428)*

(Measure 226)
Do you use Tobacco products?
(4004F)☐ YES *(PLEASE NOTIFY THE PROVIDER IF YOU WOULD LIKE INFORMATION OR COUNSELING ON STOPPING THE USE OF TOBACCO PRODUCTS)*
(1036F)☐ NO

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